Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Macotar Lodge Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	13 June 2023
Centre ID:	OSV-0001506
Fieldwork ID:	MON-0040419

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Macotar Lodge Services is a designated centre operated by Ability West. The centre can provide residential care for up to six male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one premises located in a village in Co. Galway, providing residents with their own bedroom, shared bathrooms, kitchen and dining space, sitting room, utility and staff office. A garden area is also available at the front and rear of the centre. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 13 June 2023	10:30hrs to 15:45hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow-up on non-compliance's identified during the previous inspection of this centre, to assess the provider's compliance with specific regulations and also with the regulatory compliance plan submitted to the Chief Inspector of Social Services on an organisational level.

The last inspection of this centre in February 2023, highlighted where significant change was required to the oversight and management of this centre. Although the provider had since reviewed these arrangements, it had not led to improvement in safety and support for residents. There were also continued failings found in relation to the provider's identification, response and monitoring of specific risks related in this centre. Furthermore, since the last inspection, there was also a marked decline found in aspects of residents' assessment of need and in staffing. These findings will be discussed in more detail, later on in this report.

Six residents resided in this centre, and all had lived together for quite some time. Most were of an aging profile and required various care and support with regards to their nutrition, personal, mobility, cognitive, intimate, health and behavioural care and support needs. Some had higher support needs that others, whereby, they required two-to-one staff support for most of their care needs. Since the last inspection, there were other residents who had experienced age related changing needs, where they now required increased support and supervision from staff with regards to specific aspects of their care.

Upon the inspector's arrival to the centre, they were greeted by two members of staff, who were supporting two of these residents, with the other four residents having already left for their day service. One of these residents had recently been discharged from hospital and was resting in their bedroom, while the other resident was up and about watching television and coming into the kitchen to sit by a window, as and when they pleased. Later in the day, as other residents returned from their day service, they were observed sitting in the kitchen area in the company of staff. Due to the assessed communication needs of these residents, they didn't engage directly with the inspector about the care and support they received. However, one resident did shake the inspector's hand and asked for her name.

Staff took time to talk with the inspector about each individual resident and their care and support needs. They were very familiar with the assessed needs of these residents and spoke about how some now required more assistance from staff, due to a general decline in some aspects of their health and well-being. Staff were complimentary of the support they had received in recent months from the person in charge and also from the person participating in management, who were contactable, should they have any queries. They also spoke of the on-call management system, which informed them of who they could contact, outside of normal business hours. In addition to this, they welcomed the better continuity of

staff which had occurred in recent months, whereby, when agency staff were required, it now was regular agency staff, who were familiar with the residents, that were allocated to work in this centre. Since the last inspection, the provider had improved the fire evacuation arrangements for residents, with further fire drills using minimum staffing levels, scheduled for the week of this inspection, to continue to monitor for this.

Despite this, over the course of this inspection, the inspector observed various aspects of this service that had yet to receive the change needed in order to provide a better quality of service for residents. Significant change was still required to the provider's ability to oversee specific practices that were occurring in this centre, to recognise where timely response was required in relation to incidents that were happening and to monitor that these responses were effective in providing safer and better care. The failure of the provider to make these changes, had resulted in poor outcomes for some residents and staff, particularly in instances where specific risks were not urgently mitigated against.

Capacity and capability

This centre was previously inspected in January and February 2023. Following the outcome of both inspections, the Chief Inspector had significant concerns about the arrangements in place for the effective oversight and monitoring of this centre. The inspection in January 2023 resulted in an urgent action being given to the provider, whereby, they were required to urgently review staffing levels in this centre, following an incident that had occurred, where in a resident sustained an injury. The provider did give assurances to the Chief Inspector of the actions they had taken in response to this urgent action, and a warning letter was subsequently issued to the provider from the Chief Inspector, in relation to the operations of this centre. While there were some improvements found in the February 2023 inspection, this inspection also resulted in a further urgent action being issued to this provider, this time in respect, of residents' fire evacuation arrangements. Again, the provider gave written assurances to the Chief Inspector around the action they had taken on foot of this urgent action. They also submitted a compliance plan following this inspection, outlining the action they planned to take to improve the oversight and monitoring of this centre. Since those two inspections occurred, the Chief Inspector has undertaken a targeted inspection programme with this provider across all their designated centres, specifically focusing on five regulations, to include, person in charge, staffing, governance and management, residents' assessment and personal planning and risk management. In response to this, the provider submitted an action plan to the Chief Inspector, outlining the steps they will take to improve compliance across all designated centres. This was the first inspection of this centre, since this programme commenced. The provider was again issued with an urgent action, pertaining to the safety and welfare of a resident who was experiencing a number of falls. The Chief Inspector was not assured by the initial response received from the provider in relation to this, and sought further assurances on the specific

actions that were taken.

This inspection found the provider non-compliant in all five regulations inspected against. Where the provider had previously improved aspects of this service, such as, staffing and residents' assessment arrangements, the provider had failed to ensure that those improvements were sustained. As earlier mentioned, the last two inspections found that significant change was required on the part of the provider in order to improve the quality and safety of this service. However, even though the provider had conducted a review of this centre's governance arrangements in recent months, this had not resulted in improving the oversight and monitoring of this centre.

Significant failings were again found upon this inspection, in the provider's ability to ensure that they were aware of, responding to and monitoring all specific practices and risks occurring in this centre. For instance, this inspection highlighted some care practices that were occurring outside of appropriate multi-disciplinary assessment and review. These were brought to the attention of those facilitating the inspection; however, up until this point, these practices had been occurring without the knowledge and appropriate oversight of the provider. There were also continued failings found on the part of the provider to recognise and oversee, where action was required in response to specific risk in this centre. Again it was observed, that of the incidents that the provider was aware were occurring, there was poor identification of the potential risk posed to staff and residents' safety, and an overall lack of urgency in responding to these, particularly in the area of falls management. Furthermore, there was also a noted decline in the monitoring of specific care practices in this centre, whereby, six monthly provider-led visits were overdue and internal audits had not occurred for a number of months. In conjunction with this, it had also been a number of months since a staff meeting had occurred in this centre. This resulted in key aspects of residents' care not being regularly and formally, reviewed and communicated between staff and the person in charge. In addition, where the provider had previously improved staffing arrangements in this centre, they had failed to sustain this improvement. This inspection found that where some residents' needs had changed, the provider had failed to ensure a re-assessment of their needs was completed, so as to accurately inform this centre's staffing arrangement.

Ultimately, the overall continued failings found on previous inspections and again upon this inspection, with respect to the oversight and monitoring of this centre, had a direct impact on this provider's ability to assure the Chief Inspector that they were aware of, and thoroughly overseeing and monitoring all relevant aspects of this service. The repeated failings found again on this inspection, despite the written assurances that the Chief Inspector had received from the provider, had not resulted in improved lives for residents.

Regulation 14: Persons in charge

Since the last inspection, a new person in charge was appointed to this centre. They currently had responsibility for another designated centre operated by this provider and were present in this centre, at a minimum, two days a week. However, the findings of this inspection did not assure the Chief Inspector, that their current capacity, allowed for them to ensure effective governance, operational management and administration of this designated centre.

Judgment: Not compliant

Regulation 15: Staffing

The provider had failed to ensure that residents' assessments of need were reviewed, as and when required, so as to adequately inform the staffing arrangement for this centre. For example, following the changing needs of some residents, and in response to incidents which had been occurring, the provider had not ensured that residents' assessments of need were promptly reviewed, so as to demonstrate that current staffing levels in this centre, were suitable to meet the current needs of these residents. In one instance, for one particular resident who was experiencing a number of falls, this resident's assessment of need had not been reviewed on foot of these incidents, to identify if the current staff ratio in place for this resident, was appropriate to meet their current safety and mobility needs.

Judgment: Not compliant

Regulation 23: Governance and management

On the day of inspection, in response to specific risks identified, immediate and urgent actions were required to be issued to the provider. Similar to the last inspection, an immediate action was again required to be given to the provider in relation to the obstruction of fire doors. Although the same immediate action was given to the provider on the previous inspection, their oversight of this practice since then, had proved ineffective in ensuring this practice was no longer occurring. An urgent action was issued following a review by the inspector, of falls incidents which were occurring for one particular resident, who had experienced eight falls in the four weeks leading up to this inspection. The provider was required to urgently review the arrangements in place for this resident and to provide written assurances to the Chief Inspector, that safer measures were put in place to protect the safety and welfare of this resident. This has since been satisfactory received from the provider. However, up until this inspection, the provider had failed to recognise the increased risk posed by these incidents which were continuing to occur, and to urgently respond to them in order to better the quality and safety of care in this centre.

Since the last inspection, the provider's revised oversight arrangements proved ineffective in ensuring that they were aware of, and were overseeing all specific care practices occurring in this centre. Over the course of this inspection, the inspector was made aware of two particular practices which were happening, in the absence of the knowledge and oversight on the part of the provider. The first instance, related to a physical restrictive practice, which was discontinued almost 12 months prior to this inspection. However, the inspector was informed that this was still being applied in response to the management of a resident's specific behaviour, without this resident having an appropriate multi-disciplinary assessment for this restriction, with no record of the dates or rationale for application being maintained, and no notification of this practice being notified to the Chief Inspector, as required by the regulations. Secondly, the inspector was also made aware of another practice which was in place since January 2023, where a resident's monies were being used to purchase intimate care products, as an interim arrangement, until such a time as this resident received an appropriate assessment from an allied health care professional. However, it was unclear what oversight the provider had of this process to ensure that procedures were followed in the decision-making surrounding this arrangement, and to ensure that appropriate consent was obtained from the resident involved.

The absence of effective monitoring systems also impacted the provider's ability to review specific areas of practice relevant to this service and to act upon any change needed to improve the quality and safety of care. At the time of this inspection, the six monthly provider-led audit of this centre was overdue and internal audits, which were previously completed in this centre, had not been conducted in recent months.

Although the person in charge and person participating in management maintained regular contact to review organisational matters, in recent months, staff meetings at this centre had not occurred. This had a profound impact on the provider ensuring organisational changes and resident's specific care arrangements were regularly and formally reviewed, in consultation with all staff and the person in charge, particularly in light of residents' changing needs and specific incidents that were occurring in this centre.

Judgment: Not compliant

Quality and safety

Similar to the last inspection, continued failings were found with respect to the provider's risk management system for this centre. In addition, this inspection also found that there had been a significant decline in the arrangements in place for the assessment of residents' needs.

Since the last inspection in Feb 2023, there had been a change in some residents' needs, which posed increased risk associated with some aspects of their care. The

overall risk management system that the provider had in place failed to identify these risks in a timely manner, failed to prompt urgent response when needed, and failed to monitor for re-occurrence, to ensure the safety and welfare of residents was maintained. In addition, this inspection highlighted further failings on the part of the provider, to identify all practices that were occurring in this centre and to, where necessary, ensure that these were subject to risk assessment and on-going monitoring to ensure any potential risks associated with these practices were monitored for, particularly with regards to restrictive practices and resident's monies.

Although the last inspection demonstrated improvement to the arrangements in place for the assessment of residents' needs, this improvement had not been sustained. As previously mentioned, many of these residents were experiencing changing needs; however, this inspection found that prompt re-assessment of their needs was not occurring. This was having a direct impact on the quality of personal plans available in the centre to guide staff practice, and on provider's ability to accurately inform the centre's staffing levels and supervision arrangements. Residents did have regular multi-disciplinary involvement and at the time of this inspection, a number were in the process of having further reviews from various allied health care professionals, for areas such as, behavioural support. However, for some residents, who for a number of months, were awaiting other specific assessments, improvement was required to ensure better follow-up was being made by the provider on the progress of these referrals.

Overall, these two fundamental areas of service required significant change to ensure that the provider was promptly re-assessing these residents' needs, acting quicker and effectively when risk arose, so as to better inform the quality and safety of service that these residents received.

Regulation 26: Risk management procedures

Continued failings were again found upon this inspection, in relation to the provider's ability to be fully aware of all risk in this centre, respond to information available to them about incidents that were occurring and to ensure robust systems for the monitoring of their effective mitigation.

In the weeks leading up to this inspection, a resident was experiencing a number of falls, with one of these incidents resulting in a staff member sustaining an injury. A month prior to this inspection, a re-assessment of this resident's fall management was conducted by an allied health care professional, who made recommendations with regards to mitigating against further falls from occurring. At the time of this inspection, not all of these recommendations were implemented by the provider. Furthermore, since that assessment occurred, the resident experienced eight further falls, with no further re-assessment of their falls management being completed at the time of this inspection. Although these incidents were well-reported by staff, the provider had failed to identify the continued risk to this resident, ensure that their

falls management was subject to re-assessment and to effectively put additional control measures in place to reduce the likelihood of further falls re-occurring for this resident. One of these falls had resulted in an injury to a staff member; however, no review of this incident was completed by the provider to establish any learning, or identify new measures that may be required, so as to also protect the safety and welfare of staff working in this centre.

In addition, the deficits in the oversight and monitoring of this centre, had considerably impacted on this provider's ability to identify and respond to other specific risks occurring in this centre. Where some current practices were being implemented in respect of residents' monies and in relation to restrictive practices, these had not been subject to appropriate risk assessment, control measures had not being put in place for these practices, and at the time of this inspection, were not subject to on-going monitoring by the provider for any potential risks associated with these practices, particularly in relation to safeguarding and residents' rights.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Since the last inspection, there was an overall decline found in the provider's ability to oversee that residents' assessment of need were maintained up-to-date, so to ensure these informed the personal plans guiding staff practice about the care and support residents required.

Where some residents had experienced recent changing needs, their assessment of need had not been updated to reflect this. For example, following a number of falls in this centre, a review of the assessment of need for the resident affected, had not occurred. Although a personal plan supporting this resident's falls management was in place, the guidance afforded to staff within this plan was not informed by an up-dated assessment of need.

Furthermore, there was poor follow-up of assessment referrals made in relation to some residents' care. For one resident, a personal care assessment referral was made on their behalf in January 2023. At the time of this inspection, the resident was still awaiting this assessment, with no follow-up made by the provider on the progress of the referral, since the referral was first submitted.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Macotar Lodge Services OSV-0001506

Inspection ID: MON-0040419

Date of inspection: 13/06/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The person in charge at the time of the inspection was responsible for two designated centres and was present at Macotar Lodge Services two days per week. The Provider recognizes that this is not sufficient to assure effective governance and oversight in this centre. • Immediately following inspection, the Provider implemented additional supports to enhance governance and management capacity as follows. o Two team leaders have been appointed to this centre on the 20th of June 2023. o Each team leader has 12 hours per week of supernumerary time (during waking hours) to fulfil delegated responsibilities of governance and oversight. o Responsibilities delegated to Team Leaders include (1) to ensure resident care plans are kept up to date and to identify and escalate to the person in charge if additional support requirements are identified, (2) to ensure resident risk assessment are current and accurate per resident, and to escalate any changes or increasing risks to the person in charge, (3) to schedule and facilitate resident meetings, (4) to identify training needs informed by resident's needs and escalate to the person in charge, (5) weekly and planned staffing rosters, and (6) twice a month fire drills and review of PEEPs and CEEPs. o The person in charge will meet with the team leaders weekly to review all areas of the team leader's responsibility and to provide supervision and support. • Following an external recruitment drive to employ a new person in charge (commenced May 2023), the Provider has identified a suitably qualified and experienced candidate. They have been appointed as Person in charge of Macotar Lodge Services in a full-time capacity with responsibility for this designated centre only. The person in charge will be supernumerary to rostered shifts to ensure capacity to fulfil supervision, management, administration, and governance responsibilities in the designated centre. • The newly appointed person in charge commenced induction training on 10th July 2023 which includes company induction, mandatory training and peer training with another person in charge in another designated centre. • The newly appointed person in charge will commence in post in Macotar Lodge	

Services on 19th July 2023. Their hours will be worked on a Monday to Sunday basis, 5/7 days a week across all shifts.
• The newly appointed person in charge will continue to receive the following supports:
o Support and supervision from the Area Service Manager via weekly site visits and calls.
o Weekly online management and communication meetings with a team of persons in charge from other designated centres, chaired by the Area Service Manager.
o Two team leader posts in Macotar Lodge Services, each allocated 12 hours per week
o Peer support from a person in charge from another designated centre
o Weekly visit to Macotar Lodge by a member of the Senior Management Team.
• The Provider has also assigned peer support to the person in charge. A person in charge from another designated centre is assigned four hours per week to support the person in change during their induction period.
• Staff meetings now take place every two weeks, chaired by the person in charge. These staff meetings are scheduled with an agreed agenda and minutes of the meetings are available in the staff meeting minutes folder. Attendance at staff meetings is mandatory as it is a means of consistent communication and updates, etc. for all staff.
• The Area Services Manager will be onsite a minimum weekly for support and supervision with the Person in charge. The Area Services Manager will include in these visits a review and audit of all areas across the designated centre.
• A member of the Senior Management Team will attend Macotar Lodge Services weekly for oversight of quality in services, for example to review progress against this compliance plan, to review minutes or staff and resident meetings, seek updates from the person in charge about risk register, incidents, complaints.
• The effectiveness of the local governance arrangement (i.e. person in charge and two team leaders) will be reviewed by the Area Services Manager and Director of Operational Supports and Services on a monthly basis.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• Effective from 14th June 2023, there are now four staff on duty during waking hours (increased from three) and here continues to be two staff on duty at nighttime (this remains unchanged; one waking night and one sleepover staff). This is to ensure sufficient staffing to meet the assessed support and supervision needs of all residents.
• Two additional social care workers commenced in post in Macotar Lodge services on 26th June 2023.
• Two new team leaders posts have been appointed in Macotar Lodge services on 20th June 2023. Each Team Leader is allocated 12 hours of protected time per week to fulfill delegated responsibilities from the Person in Charge. This arrangement has been implemented to ensure sufficient capacity for robust oversight of the rapidly changing needs of residents, and to ensure that needs assessments and any changes to support or staff requirements are identified promptly.
• Staff meetings, facilitated by the Person in Charge, are now held every two weeks (commenced 23rd June 2023). Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• The person in charge is responsible for ensuring that residents assessments of needs are up to date and accurate. Team leaders have delegated responsibility to update residents' needs assessments at least monthly, or more frequently if it is evidenced that a resident's needs are changing. Team leaders will report to the person in charge in their weekly meetings to assure that this level of monitoring and updating of resident's needs

is effective.
• The Area Services Manager will audit resident needs assessments on a monthly basis and report findings to the Director of Operational Supports and Services at the monthly meeting, and escalate if evidenced a need to review staffing arrangements in Macotar Lodge services.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Risk Management
In order to address the failings in the risk management process the following was undertaken:
• Risk management training was delivered by an external organization to the current Person in charge and Area Service Manager on 21st and 26th April 2023.
• Risk awareness training will be carried out with all staff in Macotar on 25th July 2023.
• The new Person in Charge will have risk management training completed on 28th July 2023.
• A review of all risks within Macotar Lodge services was undertaken by the current Person in Charge, additional controls put in place and the risk register is currently being updated and will be completed by 21st July 2023.
• The Person in Charge will review the centre risk register on a monthly basis, or more frequently where evidence of increased risk or other changes arises.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required.
• The Area Services Manager will review the risk register on a weekly basis with the person in charge and ensure that effective control measures are in place. If warranted the person in charge will escalate a risk to the Area Services Manager.
• The Area Services Manager shall present the risk register at monthly meetings to the Director of Operational Supports and Services. If warranted the Area Services Manager will escalate a risk to the Director of Operational Supports and Services.
• Where a risk cannot be safely addressed within the service the Director of Operational Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.
• Staff meetings, facilitated by the Person in Charge, are now held every two weeks (commenced 23rd June 2023). Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• The Provider's organisational policy and procedure on risk management is currently under independent external review and will be updated by 31 October 2023.

Specific risks addressed
• A magnetic closure strip has been fitted onto the fire door in the laundry room and this was completed on 10th July 2023.
• A review of restrictive practices for each resident has been completed and submitted to the Restrictive Practice Committee for review and approval on 19th July 2023.
Restrictive practices within the service will continue to be reviewed on a monthly basis by the person in charge.
• The person in charge will make relevant referrals to the Provider's Restrictive Practices

Committee for review. The Person in Charge will ensure that any referrals to the Restrictive Practices Committee will only be submitted following consultation with the resident insofar as possible, their family members and relevant members of the multi-disciplinary team.
• Restrictive practices within the service will be reviewed by the Area Service Manager on a weekly basis as part of the service review meeting.

Quality of Care Audit
• An independent external audit of the quality of care in Macotar Lodge services was carried out on the 12th and 19th July 2023. On receipt of the inspection report, an action plan, with defined timeframes and responsibilities to address all identified issues will be completed and will be documented in the service and actioned.
• The person in charge supported by team leaders will implement an updated standardised internal audit tool in Macotar Lodge. This will detail the schedule and frequency of audits to be completed on a daily, weekly and monthly basis. The audits will be reviewed by the person in charge and Area Service Manager on a weekly basis.
• In addition, this shall be audited by the Area Service Manager monthly. Audit data shall be presented to the Director of Operations at monthly meetings to assure effective auditing and reporting processes over all areas of service provision in Macotar Lodge services.
• The Provider's current Provider Led Audit structures and processes are currently under independent external review and will be updated by 31 October 2023.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to address the failings in the risk management process the following was undertaken:
• Risk management training was delivered by an external organization to the current Person in charge and Area Service Manager on 21st and 26th April 2023.
• Risk awareness training will be carried out with all staff in Macotar on 25th July 2023.
• The new Person in Charge will have risk management training completed on 28th July 2023.
• A review of all risks within Macotar Lodge services was undertaken by the current Person in Charge, additional controls put in place and the risk register is currently being updated and will be completed by 21st July 2023.
• The Person in Charge will review the centre risk register monthly, or more frequently where evidence of increased risk or other changes arises.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence, or other indicators that a review of risk in respect of a resident or risk category is warranted.
• The Area Services Manager will review the risk register on a weekly basis with the person in charge and ensure that effective control measures are in place. If warranted the person in charge will escalate a risk to the Area Services Manager.
• The Area Services Manager shall present the risk register at monthly meetings to the Director of Operational Supports and Services. If warranted the Area Services Manager will escalate a risk to the Director of Operational Supports and Services.
• Where a risk cannot be safely addressed within the service the Director of Operational

Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.
• Staff meetings, facilitated by the Person in Charge, are now held every two weeks (commenced 23rd June 2023). Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• The Provider's organisational policy and procedure on risk management is currently under independent external review and will be updated by 31 October 2023.

Specific risks addressed:
• A magnetic closure strip has been fitted onto the fire door in the laundry room and this was completed on 10th July 2023.
• A review of restrictive practices for each resident has been completed and submitted to the Restrictive Practice Committee for review and approval on 19th July 2023. Restrictive practices within the service will continue to be reviewed monthly by the person in charge.
• The person in charge will make relevant referrals to the Provider's Restrictive Practices Committee for review. The Person in Charge will ensure that any referrals to the Restrictive Practices Committee will only be submitted following consultation with the resident insofar as possible, their family members and relevant members of the multi-disciplinary team.
• Restrictive practices within the service will be reviewed by the Area Service Manager on a weekly basis as part of the service review meeting.

In addition, the Provider undertook urgent actions following the inspection on 13 June 2023:
• Updated Multi-Disciplinary assessment and review of resident who has suffered several falls in the service.
o Physiotherapy assessment 15th June 2023.
o Occupational Therapy review and assessment 19th June 2023.
o Joint Multi-Disciplinary Therapy review with person in charge and manager of the resident's day service on 20th June 2023.
o The outcome of these reviews resulted in the resident's care plan being updated, staff supervision arrangements have been enhanced, and updates from these assessments were discussed with staff at a staff meeting on 23rd June 2023.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Need assessments have now been reviewed and updated for all residents by the Person in Charge and Area Services Manager.
• The person in charge is responsible for ensuring that residents' assessments of needs are up to date and accurate. Team leaders have delegated responsibility to update residents' needs assessments at least monthly, or more frequently if it is evidenced that a resident's needs are changing. Team leaders will report to the person in charge in their weekly meetings to assure that this level of monitoring and updating of residents' needs is effective.
• The Area Services Manager will audit resident needs assessments on a monthly basis

and report findings to the Director of Operational Supports and Services at the monthly meeting, and escalate if evidenced a need to review staffing arrangements in Macotar Lodge services.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required.
• Staff meetings, facilitated by the person in charge, are now held every two weeks (commenced 23rd June 2023). Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• The person in charge has reassigned keyworkers to each resident, with delegated responsibilities for supporting residents with their personal plans and support. The Team Leaders and Person in Charge will guide and support keyworkers to ensure that support plans and Person-Centered Care Plans are reviewed and updated monthly or more frequently, as required.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	24/07/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	12/07/2023
Regulation	The registered	Not Compliant	Orange	17/07/2023

23(1)(c)	provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	17/07/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	14/06/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social	Not Compliant	Orange	31/07/2023

	care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			